



## MAINE STATE BOARD OF NURSING

158 State House Station • Augusta, ME 04333-0158  
Phone (207) 287-1133 Fax (207) 287-1149 TDD (207) 287-1151

### APPLICATION FOR EXAMINATION AND LICENSE AS A REGISTERED PROFESSIONAL NURSE

#### DO NOT WRITE IN THIS SPACE

Application Received \_\_\_\_\_

Application approved by Board of Nursing: \_\_\_\_\_

Fee: Cash \_\_\_\_\_ Check \_\_\_\_\_ MO \_\_\_\_\_

Chair

Receipt # \_\_\_\_\_

Examination Date \_\_\_\_\_

Executive Director

Re-examination Date(s) \_\_\_\_\_

License Date \_\_\_\_\_

Date

LICENSE NUMBER \_\_\_\_\_

**INSTRUCTIONS.** An applicant for the registered nurse examination and license must submit to the office of the Board of Nursing at least 30 days before the scheduled date of the licensure examination the following:

1. application form completed in ink or typewritten and properly notarized with signature in applicant's handwriting, and
2. required fee of ~~75.00~~ in the form of a check or money order, made payable to the Treasurer of State of Maine, and
3. recent passport type photograph (not more than two years old), signed and dated and enclosed with application form as indicated.

#### THE APPLICATION FEE IS NOT REFUNDABLE

### SECTION I. PROFILE INFORMATION

Print legal name \_\_\_\_\_  
(first) (middle) (maiden) (last)

List any other names used previously \_\_\_\_\_

Residential address \_\_\_\_\_  
(street and number or route)

(city)

(county)

(state and zip code)

Mailing address (if different from above) \_\_\_\_\_

Telephone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

Birthplace \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(city/state) (month/day/year)

High School \_\_\_\_\_  
(name and location)

Date of Graduation \_\_\_\_\_ G.E.D. ☐ Yes ☐ No Date of G.E.D. Diploma \_\_\_\_\_

## SECTION II. BASIC NURSING EDUCATION

School of Nursing \_\_\_\_\_  
(name)  
\_\_\_\_\_  
(address)

Date of Entrance \_\_\_\_\_ Date of Graduation \_\_\_\_\_ Length of Program \_\_\_\_\_

Diploma                      Associate                      Baccalaureate                      Masters

Have you ever been licensed as a practical nurse?      ☐ Yes      ☐ No

If yes, indicate state(s), date(s), of licensure and license number(s).

## SECTION III. TO BE COMPLETED BY ADMINISTRATIVE OFFICER OF SCHOOL OF NURSING

I hereby certify that \_\_\_\_\_  
(applicant's name)

\_\_\_\_\_  
(applicant's address)

successfully completed the prescribed nursing education program in the

\_\_\_\_\_  
(name of school)

on \_\_\_\_\_  
(month/day/year)

\_\_\_\_\_  
(signature)

SCHOOL SEAL

\_\_\_\_\_  
(title)

\_\_\_\_\_  
(name of school)

## SECTION IV. EXAMINATION HISTORY

Have you ever taken an examination for registered nurse licensure?

☐ Yes      If yes, indicate state(s) and date(s).

☐ No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SECTION V. RESIDENCE INFORMATION

What state (or country if you are not from the U.S.) do you claim as your legal residence?

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## SECTION VI. OTHER INFORMATION

Have you ever been convicted of a crime other than minor traffic violations?

- ☐ Yes (If yes, describe the nature of the crime including its disposition. You are required to submit copies of all relevant court records.)
- ☐ No

**THIS FORM MUST BE NOTARIZED**

TAPE TOP ONLY  
one recent photograph

Sign back of photo and  
indicate year taken

Photo must be:

Full face view

Passport type

Clear and recognizable  
likeness

I, the undersigned, being duly sworn, say that I am the person referred to in this application for licensure in the State of Maine, that the statements contained herein and on all attachments are true and correct in every respect, that I have complied with all requirements of the law, and that I have read and understand this affidavit.

Signature of Applicant \_\_\_\_\_

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

(SEAL)

Notary Public \_\_\_\_\_

My commission expires \_\_\_\_\_ in and for the State of \_\_\_\_\_



STATE OF MAINE  
BOARD OF NURSING  
158 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0158

JOHN ELIAS BALDACCI  
GOVERNOR

MYRA A. BROADWAY, J.D., M.S., R.N.  
EXECUTIVE DIRECTOR

**DECLARATION OF PRIMARY STATE OF RESIDENCE**

Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Permanent/Residential Address:

\_\_\_\_\_  
(Apartment #, RR#, Street)

\_\_\_\_\_  
(City, State, and Zip Code)

Mailing address: (If same as above check here \_\_\_\_\_)

\_\_\_\_\_  
(PO Box, Apartment #, RR#, Street)

\_\_\_\_\_  
(City, State, and Zip Code)

Telephone Number \_\_\_\_\_ Email address: \_\_\_\_\_

( ) Yes ( ) No Are you currently employed in the U.S. Military (Active Duty) or  
the U.S. Federal Government?

In accordance with Chapter 11 Regulations Relating to the Nurse Licensure Compact  
Part II, 2.a. of the Nurse Licensure Compact Rules and Regulations, I declare that the  
State of \_\_\_\_\_ is my primary state of residence and is my legal state of residence.

I affirm that the contents of this document are true and correct to the best of my  
knowledge and belief. Providing false or misleading information may result in  
disciplinary action by the Board.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)



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